FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035659

Facility Name: TAMMERLANE HEALTH CARE CENTRE

Address: 3601 SIXTEENTH AVENUE (Number) STERLING (City) 61081 (Zip Code)

County: WHITESIDE

Telephone Number: (815) 626-0233 **Fax #** (815) 626-6740

IDPA ID Number: 36-3651798

Date of Initial License for Current Owners: 07/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROBERT HEDGES
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	23,349	1,096		24,445	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,349	1,096		24,445	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.68%

D. How many bed-hold days during this year were paid by the Department?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	107,029	10,288	4,610	121,927		121,927		121,927			1
2	Food Purchase		103,418		103,418	(7,172)	96,246	(14)	96,232			2
3	Housekeeping	59,558	13,816		73,374		73,374		73,374			3
4	Laundry	18,620	3,013	119	21,752		21,752		21,752			4
5	Heat and Other Utilities			49,338	49,338		49,338	758	50,096			5
6	Maintenance	35,548	6,045	22,095	63,688		63,688	3,523	67,211			6
7	Other (specify):*			3,526	3,526		3,526		3,526			7
8	TOTAL General Services	220,755	136,580	79,688	437,023	(7,172)	429,851	4,267	434,118			8
	B. Health Care and Programs											
9	Medical Director			12,317	12,317		12,317		12,317			9
10	Nursing and Medical Records	471,995	19,998	550	492,543		492,543		492,543			10
10a	Therapy			3,088	3,088		3,088		3,088			10a
11	Activities	44,536	1,538		46,074		46,074		46,074			11
12	Social Services	103,382		3,265	106,647		106,647		106,647			12
13	CNA Training											13
14	Program Transportation			5,246	5,246		5,246		5,246			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	619,913	21,536	24,466	665,915		665,915		665,915			16
	C. General Administration											
17	Administrative	77,988		123,000	200,988		200,988	(57,843)	143,145			17
18	Directors Fees											18
19	Professional Services			45,393	45,393		45,393	(17,330)	28,063			19
20	Dues, Fees, Subscriptions & Promotions			10,224	10,224		10,224	(645)	9,579			20
21	Clerical & General Office Expenses	18,242	7,527	13,800	39,569		39,569	17,543	57,112			21
22	Employee Benefits & Payroll Taxes			167,053	167,053	7,172	174,225		174,225			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,567	2,567		2,567	1,910	4,477			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,052	46,052		46,052	1,743	47,795			26
27	Other (specify):*			26,615	26,615		26,615	(11,794)	14,821			27
28	TOTAL General Administration	96,230	7,527	434,704	538,461	7,172	545,633	(66,416)	479,217			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	936,898	165,643	538,858	1,641,399		1,641,399	(62,149)	1,579,250			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: TAMMERLANE HEALTH CARE CENTRE #0035659 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,610	
	REPAIRS & MAINTENANCE		0	
			0	4,610
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		119	
			0	119
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		20,435	
	ELECTRICITY		15,603	
	WATER		12,787	
	CABLE TV - LOBBY		513	
			0	49,338
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,968	
	PAINTING & DECORATING		3,083	
	BUILDING REPAIRS		6,206	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		3,511	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		926	
	FIRE SERVICE		6,401	
			0	
			0	
			0	22,095
7	**OTHER**			
	SCAVENGER		3,526	
	SECURITY SERVICE		0	3,526
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	13,067	12,317

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	550	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	550
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	3,088	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	3,088
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		1,265	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,000	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	3,265
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE #0035659 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		5,246	5,246
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	123,000	123,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,459	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	30,934	
			0	45,393
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	24	
	EMPLOYEE WANT ADS	XIX F	767	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	7,207	
	LICENSES & PERMITS	XIX F	431	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	298	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	965	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	532	10,224
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,046	
	EQUIPMENT REPAIR & MAINTENANCE		779	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	(492)	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		10,467	
	MESSENGER SERVICE		0	
			0	13,800

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	71,673	
	UNEMPLOYMENT COMPENSATION	XIX D	13,320	
	WORKERS COMPENSATION INSURANCI	XIX D	33,105	
	HOSPITALIZATION INSURANCE	XIX D	44,054	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,901	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	167,053
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	2,567	
	TRAVEL	XIX G	0	
			0	
			0	2,567
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		0	0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		46,052	46,052
27	**OTHER**			
	BAD DEBTS	VI 24	26,615	
				26,615

GRAND TOTAL COLUMN 3 OTHER 538,858

TAMMERLANE HEALTH CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	103,418
LESS SALES TAX	(14)
NET FOOD	103,404
TOTAL PATIENT CENSUS	24,445
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	73335
ADD # EMPLOYEE MEALS/DAY	15
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	5475

PATIENT MEALS	73335
ADD EMPLOYEE MEALS	5475
TOTAL MEALS/YEAR	78810
NET FOOD	103404
DIVIDE TOTAL MEALS/YEAR	78810
COST PER MEAL	1.31
TIME EMPLOYEE MEALS	5475
EMPLOYEE MEAL RECLASSIFICATION	7172

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE #0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			17,064	17,064		17,064	36,495	53,559			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,985	31,985		31,985	90,748	122,733			32
33	Real Estate Taxes			17,351	17,351		17,351		17,351			33
34	Rent-Facility & Grounds			169,035	169,035		169,035	(169,035)				34
35	Rent-Equipment & Vehicles			7,038	7,038		7,038		7,038			35
36	Other (specify):*											36
37	**TOTAL Ownership**			242,473	242,473		242,473	(41,792)	200,681			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,325	38,325		38,325		38,325			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			38,325	38,325		38,325		38,325			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	936,898	165,643	819,656	1,922,197		1,922,197	(103,941)	1,818,256			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,904	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(14)	2		13
14	Non-Care Related Interest	(3,206)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	492	21		18
19	Entertainment		20		19
20	Contributions	(965)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,615)	27		24
25	Fund Raising, Advertising and Promotional	(24)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(298)	20		28
29	Other-Attach Schedule	(23,367)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (51,093)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(52,848)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (52,848)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (103,941)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

TAMMERLANE HEALTH CARE CENTRE

ID# 0035659

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (2,321)	6	1
2	BANK CHARGES	(3,046)	21	2
3	DATA PROCESSING-HEALTHCARE HORIZONS	(7,000)	19	3
4	OTHER PROF FEES- HEALTHCARE HORIZONS	(11,000)	19	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(23,367)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14)	0	0	0	0	0	0	0	0	0	0	(14)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	758	0	0	0	0	0	0	0	0	0	758	5
6	Maintenance	(2,321)	5,844	0	0	0	0	0	0	0	0	0	3,523	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,335)	6,602	0	0	0	0	0	0	0	0	0	4,267	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(57,843)	0	0	0	0	0	0	0	0	0	(57,843)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,000)	670	0	0	0	0	0	0	0	0	0	(17,330)	19
20	Fees, Subscriptions & Promotions	(1,287)	642	0	0	0	0	0	0	0	0	0	(645)	20
21	Clerical & General Office Expenses	(2,554)	20,097	0	0	0	0	0	0	0	0	0	17,543	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,910	0	0	0	0	0	0	0	0	0	1,910	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,743	0	0	0	0	0	0	0	0	0	1,743	26
27	Other (specify):*	(26,615)	14,821	0	0	0	0	0	0	0	0	0	(11,794)	27
28	**TOTAL General Administration**	(48,456)	(17,960)	0	0	0	0	0	0	0	0	0	(66,416)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,791)	(11,358)	0	0	0	0	0	0	0	0	0	(62,149)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,904	0	33,019	572	0	0	0	0	0	0	0	36,495	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,206)	0	92,962	992	0	0	0	0	0	0	0	90,748	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(169,035)	0	0	0	0	0	0	0	0	(169,035)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(302)	0	(43,054)	1,564	0	0	0	0	0	0	0	(41,792)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(51,093)	(11,358)	(43,054)	1,564	0	0	0	0	0	0	0	(103,941)	45

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WILLIAM IRVINE	50			HI CARE MGMT.	SPRINGFIELD	MANAGEMENT
ROBERT HEDGES	50			H&I PROPERTIES	SPRINGFIELD	LANDLORD
		SEE ATTACHED SCHEDULE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 123,000	HI CARE MANAGEMENT		$	$ (123,000)	1
2	V	5	UTILITIES				758	758	2
3	V	6	MAINTENANCE				5,844	5,844	3
4	V	17	OFFICER SALARY				47,683	47,683	4
5	V	17	DIRECTOR OF OPERATIONS				6,574	6,574	5
6	V	17	DIRECTOR OF FINANCE				10,900	10,900	6
7	V	19	PROFESSIONAL FEES				670	670	7
8	V	20	DUES & SUBSCRIPTION				642	642	8
9	V	21	OFFICE EXPENSE				20,097	20,097	9
10	V	24	TRAVEL & SEMINARS				1,910	1,910	10
11	V	26	INSURANCE				1,743	1,743	11
12	V	27	PAYROLL TAXES & GRP INS				14,821	14,821	12
13	V								13
14	Total			$ 123,000			$ 111,642	$ * (11,358)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 169,035	H & I PROPERTIES		$	$ (169,035)	15
16	V	30	DEPRECIATION		H & I PROPERTIES		33,019	33,019	16
17	V	32	INTEREST		H & I PROPERTIES		92,962	92,962	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 169,035			$ 125,981	$ * (43,054)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	H & I PROPERTIES		$ 572	$ 572	15
16	V	32	INTEREST		H & I PROPERTIES		992	992	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 1,564	$ * 1,564	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRI # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.						$		1
2	TOTAL SALARY RECEIVED FROM HI CARE $170,000			0.50					23,841	17-8	2
3											3
4											4
5											5
6	WILLIAM IRVINE	VICE-PRESIDENT	OFFICE MGMT.								6
7	TOTAL SALARY RECEIVED FROM HI CARE $170,000			0.50					23,842	17-8	7
8											8
9											9
10	MARTHA IRVINE	BOOKKEEPING									10
11	TOTAL SALARY RECEIVED FROM HI CARE $6672								936	21-8	11
12											12
13								TOTAL	$ 48,619		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HI CARE MANAGEMENT
Street Address: 827 S. FIFTH STREET
City / State / Zip Code: SPRINGFIELD, IL 62703
Phone Number: (217) 528-0044
Fax Number: (217) 528-3412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	174,304	7	$ 5,408	$	24,445	$ 758	1
2	6	MAINTENANCE	PER RESIDENT DAY	174,304	7	41,669	34,507	24,445	5,844	2
3	17	OFFICER SALARY	PER RESIDENT DAY	174,304	7	340,000	340,000	24,445	47,683	3
4	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	174,304	7	46,873	46,873	24,445	6,574	4
5	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	174,304	7	77,723	77,723	24,445	10,900	5
6	19	PROFESSIONAL FEES	PER RESIDENT DAY	174,304	7	4,774		24,445	670	6
7	20	DUES & SUBSRIPTION	PER RESIDENT DAY	174,304	7	4,580		24,445	642	7
8	21	OFFICE EXPENSE	PER RESIDENT DAY	174,304	7	143,304	89,662	24,445	20,097	8
9	24	TRAVEL & SEMINARS	PER RESIDENT DAY	174,304	7	13,622		24,445	1,910	9
10	26	INSURANCE	PER RESIDENT DAY	174,304	7	12,425		24,445	1,743	10
11	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	174,304	7	105,677		24,445	14,821	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 796,055	$ 588,765		$ 111,642	25

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: H & I PROPERTIES-NSG FACILTIY
Street Address: 1625 S SIXTH STREET
City / State / Zip Code: SPRINGFIELD IL 62703
Phone Number: (217)528-0044
Fax Number: (217)528-0412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 33,019	$	1	$ 33,019	1
2	32	INTEREST	DIRECT	1	1	92,962		1	92,962	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 125,981	$		$ 125,981	25

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: H & I PROPERTIES-OFFICE BUILDING
Street Address: 1625 S SIXTH STREET
City / State / Zip Code: SPRINGFIELD IL 62703
Phone Number: (217)528-0044
Fax Number: (217)528-0412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	PER LICENSE BED	639	7	$ 5,226	$	70	$ 572	1
2	32	INTEREST	PER LICENSE BED	639	7	9,051		70	992	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 14,277	$		$ 1,564	25

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	GMAC		X	AUTO LOAN	$699.00	11/18/02	$ 28,556	$ 8,040	12/03/06	0.0799	$ 1,003	1
2	ILLINI BANK		X	AUTO LOAN	$255.00	02/17/04	10,750	6,160	02/17/08	0.0650	488	2
3	related party office-us bank		X	MORTGAGE	$2,066.64	6/29/5	290,000	279,382	06/29/12	0.0635	992	3
4	related party-illini bank		X	MORTGAGE	$11,067.00	6/11/02	1,160,130		5/30/05	0.0725	63,416	4
5	related party-cole taylor		X	MORTGAGE	$13,098.68	08/03/05	1,689,500	1,683,321	08/01/10	0.0700	29,546	5
	Working Capital											
6	ILLINI BANK		X	WORKING CAPITAL	INTEREST	REVOLV		197,973	REVOLV	PRIME +	30,092	6
7	ILLINI BANK		X	BOILER	$271.00	11/12/03	8,500	2,846	11/12/06	0.0913	402	7
8												8
9	TOTAL Facility Related				$27,457.32		$ 3,187,436	$ 2,177,722			$ 125,939	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,187,436	$ 2,177,722			$ 125,939	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	15,483	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	16,417	2
3. Under or (over) accrual (line 2 minus line 1).	$	934	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	16,417	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	17,351	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	14,355	8
2001	14,537	9
2002	15,117	10
2003	15,483	11
2004	16,417	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TAMMERLANE HEALTH CARE CENTRE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0035659

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-10-329-006	NURSING HOME	$ 16,416.80	$ 16,416.80
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 16,416.80	$ 16,416.80

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,130 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	217,800	1998	$ 111,500	1
2					2
3	TOTALS	217,800		$ 111,500	3

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	70		1998	1958	$ 887,968	$ 22,769	39	$ 22,769	$	$ 167,921	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENTS			1992	14,227	452	31.5	452		5,992	9
10	IMPROVEMENTS			1993	3,670	94	39	94		1,148	10
11	IMPROVEMENTS			1994	7,850	201	39	201		2,233	11
12	PLUMBING WORK			1995	3,302	85	39	85		903	12
13	INSTALLED BOILER TANK			1995	600	15	39	15		160	13
14	INSTALLED 2 PUMPS			1995	2,289	59	39	59		622	14
15	PLUMBING WORK			1995	10,752	276	39	276		2,887	15
16	DOORS			1995	2,094	54	39	54		551	16
17	TWO DOORS			1995	1,055	27	39	27		273	17
18	INSTALLED ATTIC FAN & DUCT			1995	2,412	62	39	62		623	18
19	PARKING LOT			1995	32,070	2,138	39	2,138		22,004	19
20	WALL PROTECTOR			1997	3,328	85	39	85		748	20
21	SEPTIC FIELD-PLUMBING WORK			1998	25,965	666	39	666		4,745	21
22	2 NEW WATER HEATERS			1999	12,083	310	39	310		2,027	22
23	CIRCUIT BREAKER PANELS			1999	2,230	57	39	57		373	23
24	ELECTRICAL WORK			1999	2,374	61	39	61		399	24
25	BREAKER PANELS			2001	2,542	92	27.5	92		418	25
26	BLACKTOP			2001	11,161	744	15	744		3,379	26
27	BOILER			2003	9,911	360	37.5	360		735	27
28	WINDOWS			2005	1,832	8	27.5	8		8	28
29	MAIN BREAKER PANEL			2005	13,684	63	27.5	63		63	29
30	DIRECT SUPPLY			2005	20,688	31	27.5	31		31	30
31	CONCRETE WALKWAY			2005	1,800	25	15	25		25	31
32	FIRE SYSTEM			2005	1,769	8	27.5	8			32
33											33
34											34
35											35
36	H & I PROPERTIES-OFFICE BUILDING			2005	28,783	572	39	572		572	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,106,439	$ 29,314		$ 29,314	$	$ 218,840	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 48,712	$ 2,430	$ 4,658	$ 2,228	10	$ 38,187	71
72	Current Year Purchases	29,611	1,323	1,481	158	10	1,481	72
73	Fully Depreciated Assets	15,890				10	15,890	73
74	RELATED PARTY	102,500	10,250	10,250		10	76,875	74
75	TOTALS	$ 196,713	$ 14,003	$ 16,389	$ 2,386		$ 132,433	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSKP,NSG,ACT	2000 CHEVY TRUCK	2002	$ 28,556	$ 3,906	$ 5,711	$ 1,805	5	$ 19,989	76
77	HSKP,NSG,ACT	2001 DODGE VAN	2004	10,725	3,432	2,145	(1,287)	5	4,290	77
78										78
79										79
80	TOTALS			$ 39,281	$ 7,338	$ 7,856	$ 518		$ 24,279	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,453,933	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 50,655	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 53,559	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,904	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 375,552	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		70		$ 169,035			3
4	Additions							4
5								5
6								6
7	TOTAL		70		$ 169,035 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$ 169,035
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 7,038 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE **#** 0035659 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 42,167	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (15,000))	400,728		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,339		6
7	Other Prepaid Expenses	2,357		7
8	Accounts Receivable (owners or related parties)	121,071		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 610,662	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	189,688		15
16	Equipment, at Historical Cost	133,494		16
17	Accumulated Depreciation (book methods)	(150,713)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): conputer software	7,448		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 179,917	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 790,579	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 135,313	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	215,019		29
30	Accrued Salaries Payable	31,734		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,626		31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,417		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 412,109	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	22,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 22,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 434,109	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 356,470	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 790,579	$	48

***(See instructions.)**

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 206,311	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 206,313	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	150,157	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 150,157	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 356,470	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,069,148	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,069,148	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,206	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,206	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,072,354	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	437,023	31
32	Health Care	665,915	32
33	General Administration	538,461	33
	B. Capital Expense		
34	Ownership	242,473	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	38,325	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,922,197	40
41	**Income before Income Taxes (line 30 minus line 40)****	150,157	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 150,157	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,850	2,080	$ 54,080	$ 26.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,197	3,466	94,239	27.19	3
4	Licensed Practical Nurses	7,257	7,985	143,029	17.91	4
5	CNAs & Orderlies	18,289	19,706	155,056	7.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,838	2,075	18,271	8.81	9
10	Activity Assistants	3,695	3,972	26,265	6.61	10
11	Social Service Workers	9,593	10,446	103,382	9.90	11
12	Dietician					12
13	Food Service Supervisor	1,868	1,983	17,941	9.05	13
14	Head Cook	8,307	8,901	60,939	6.85	14
15	Cook Helpers/Assistants	4,017	4,232	28,149	6.65	15
16	Dishwashers					16
17	Maintenance Workers	3,878	4,268	35,548	8.33	17
18	Housekeepers	7,493	8,255	59,558	7.21	18
19	Laundry	2,661	2,808	18,620	6.63	19
20	Administrator	1,856	2,080	77,988	37.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,149	1,310	18,242	13.93	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS	638	650	11,288	17.37	32
33	Other(specify) Transportation	2,004	2,100	14,303	6.81	33
34	TOTAL (lines 1 - 33)	79,590	86,317	$ 936,898 *	$ 10.85	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 4,610	1-3	35
36	Medical Director	O	13,067	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	550	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	3,088	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,000	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 23,315		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHELLY REESE	ADMIN		$ 77,988
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,988

B. Administrative - Other

Description	Amount
HI-CARE MANAGEMENT	$ 123,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 123,000

C. Professional Services

Vendor/Payee	Type	Amount
HEALTHCARE HORIZONS	DATA PROCESSING	$ 7,000
ACHIEVE SOFTWARE	DATA PROCESSING	5,223
VISA	DATA PROCESSING	186
NIHAN & MARTIN	DATA PROCESSING	2,050
KRUPNICK, BOKOR, KAGDA	ACCOUNTING	18,950
PERSONNEL PLANNERS	UNEMPLOYMENT CONSLT	984
HEALTHCARE HORIZONS		11,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 45,393

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 33,105
Unemployment Compensation Insurance		13,320
FICA Taxes		71,673
Employee Health Insurance		44,054
Employee Meals		7,172
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		4,901
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 174,225

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	767
Health Care Worker Background Check	532
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	322
TRUST/FRANCHISE/CONTRIB/ETC	965
LICENSES & PERMITS	431
DUES & SUBSCRIPTIONS	7,207
MGMT CO ALLOCATION	642
TRUST/FRANCHISE/CONTRIB/ETC	(965)
Less: Public Relations Expense	(0)
Non-allowable advertising	(24)
Yellow page advertising	(298)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,579

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MNGMNT COMPANY ALLOC	1,910
Seminar Expense	
	2,567
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,477

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	06/00	$ 1,588	3 YRS	$ 529	$ 529	$ 265	$	$	$	$	$	$
2	PAINT/DECORATING	06/02	1,485	3 YRS	248	495	495	247					
3	PAINT/DECORATING	06/05	3,083	3 YRS				515	1,027	1,027	514		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,156		$ 777	$ 1,024	$ 760	$ 762	$ 1,027	$ 1,027	$ 514	$	$

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC $2770, IL HEALTH CARE $4200**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **38,325**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,172** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees